

Member Reimbursement Pharmacy Form

Please read the back for instructions. Complete all information.
An incomplete form may either delay your reimbursement or may be returned for additional information.

Complete and return this form when you have purchased a covered prescribed prescription drug at retail cost and are seeking reimbursement. Submit this form with the original prescription label receipt(s). Cash register and credit card receipts alone are not acceptable as proof of purchase. Reimbursement is not guaranteed. Claims will be reviewed, subject to limitations, exclusions and other provisions of the Plan Benefit.

Member/Subscriber Information (See your ID card.)

RxGrp
Member ID

Member Name (Last, First) _____

Street Address _____

City _____

State ZIP

Patient Information

Patient Name (Last, First) _____

Patient Date of Birth (Month/Day/Year)

Gender Relationship to Member/Subscriber
☐ Female ☐ 1 Self ☐ 5 Disabled Dependent
☐ Male ☐ 2 Spouse ☐ 6 Dependent Partner
☐ 3 Eligible Child ☐ 7 Nonspouse Partner
☐ 4 Dependent Student ☐ 8 Other

Pharmacy and Prescribing Physician Information

Name of Pharmacy _____

Street Address _____

City _____

State ZIP

Telephone (Include Area Code) _____

X

Signature of Pharmacist or Representative (If required by your pharmacy plan) _____ NCPDP#NPI# (Pharmacy Account Number)(11 Digit Number)

Prescribing Physician Name and Phone Number _____

Acknowledgement

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Member/Subscriber _____



Claim Receipts

(Please read Section A on back for details.)

Check the appropriate box if your receipts are for a:

- ☐ **Compound prescription**
Please have your pharmacist complete Section A below. Make sure your pharmacist lists ALL the VALID 11 digit NDC numbers and ingredients and quantities on the claim form.
- ☐ **Medication purchased outside of the United States**
Please indicate:
Country _____
Currency used _____
- ☐ **Allergy medication**
(if covered by your pharmacy plan)

Coordination of Benefits

(Another Health Plan has paid a portion)
Is this a coordination of benefits claim?

☐ Yes ☐ No

If yes, please read Section B on back for details, and mark the appropriate box for your primary coverage method.

- ☐ 1 You are submitting an Explanation of Benefits (EOB) from another Health Plan or from Medicare
- ☐ 3 You are submitting a copy receipt

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*